

MEDICAL ASSISTANCE ADMINISTRATION



Prescription Drug Program

Billing Instructions

December 1998

(WAC 388-530)

About this publication

This publication supersedes all previous MAA Prescription Drug Program Billing Instructions, as well as the following publications:

Numbered Memorandums: 97-01, 97-03, 97-35, 97-60, 97-62, 97-64, 97-67, 97-74, 98-34.
Medical News Bulletins: 11/95 #2, 5/97 #1

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Olympia, WA 98504-5562

Table of Contents

Important Contacts	iv
Definitions	1

Drug Program	A.1
What is the goal of the Prescription Drug Program?	
Who may prescribe, administer, or dispense...?	
Guidelines for completing prescription forms which will be filled by a pharmacist	
National Association of Boards of Pharmacy (NABP) Number	
Billing a Medical Assistance Client	
Abuse and Misutilization	

Client Eligibility.....	B.1
Types of identification that prove eligibility	
Who is eligible?	
Who is not eligible?	
“Restricted” Clients	
Hospice Clients	
What about managed care clients?	
Family Planning Only Clients	
Third Party Liability	
Medicare/Medicaid Benefits Coordination	

Coverage/Program Limitations	C.1
What drugs and pharmaceutical supplies <u>are</u> covered?	
What drugs and pharmaceutical supplies are <u>not</u> covered?	
Is there a “Days Supply” limit?	
How many prescriptions are allowed per month...?	
Which drugs may be dispensed without prescription?	
Is it possible to receive early refills?	
Generic Drugs	
Cost Per Milligram (mg) Savings	
Clozaril and Related Services	

Compliance Packaging	D.1
What is included in compliance packaging?	
How do I determine if a client is eligible for compliance packaging?	
How do I bill for compliance packaging?	
 Nursing Facilities	 E.1
Products that are <u>not</u> reimbursed by MAA when the client resides in a nursing facility	
Medications for nursing facility clients on leave	
Emergency Kits	
Nursing Facility Unit Dose Delivery Systems	
How do pharmacies become eligible for a unit dose dispensing fee?	
How do pharmacies bill MAA under a true or modified unit dose delivery system?	
Who is responsible for the cost of repackaging client's bulk medications?	
What do pharmacies need to keep in their records?	
What needs to be submitted annually to MAA?	
 Compounded Prescriptions	 F.1
Items which are not covered for compounding	
Chemical supplies	
How to bill for compounded prescriptions	
Is prior authorization required for compounded prescriptions?	
 Prior Authorization	 G.1
When should a pharmacist obtain prior authorization?	
What information should a pharmacist have ready before calling MAA for an authorization number?	
Where to call for prior authorization	
What to do if a pharmacist receives a denial code	
 Expedited Authorization	 H.1
Expedited Authorization Coding List	
Revia (Naltrexone) Authorization Form (DSHS 13-677)	
 Medicare Part B/Medicaid Crossover Claim Form	 I.1
Sample Medicare Part B/Medicaid Crossover HCFA-1500 Claim Form	

Reimbursement	J.1
General Information	
Payment	
Tax	
Estimated Acquisition Cost (EAC)	
Dispensing Fees	
Drug Quantities	
 Point-of-Sale (POS)	 K.1
What is Point-of-Sale (POS)?	
Do pharmacies have to use the on-line POS system?	
Do pharmacies need a separate agreement with MAA to use POS?	
How long do I have to bill?	
How do I bill for a baby who is using his/her parent's PIC?	
National Drug Code (NDC)	
Overriding a PRO-DUR denied claim	
MAA-Approved NCPDP DUR Codes	
Prospective Drug Use Review Edits	
NCPDP Payor Sheet for Washington Medicaid	
Other Information	
 Completing Pharmacy Statement Form 525-106	 L.1
Sample: Pharmacy Statement Claim Form (525-106)	
 Maximum Allowable Cost Program	 M.1
Automated Maximum Allowable Cost (AMAC) Program	
Maximum Allowable Cost Program (MAC)	
Maximum Allowable Cost Fee Schedule	
 Over-the-Counter (OTC) Medications	 N.1
Over-the-Counter Medications List	
 Less-Than-Effective Drug Index	 O.1
Less-Than-Effective Drug Index	

Drug Rebate Program P.1

Alphabetic List of HCFA Drug Rebate Contract Manufacturers
Numeric List of HCFA Drug Rebate Contract Manufacturers

Drug Formulary Q.1

Drug Formulary Index

Important Contacts

Where do I call for information on becoming a DSHS provider, submitting a provider change of address or ownership, or to ask questions about the status of a provider application?

Call the toll-free line:
(866) 545-0544

Where do I send hardcopy claims?

Division of Program Support
PO Box 9245
Olympia WA 98507-9245

Who do I call for prior authorization?

Drug Utilization and Review
1-800-848-2842

Mail or fax backup documentation ONLY
to:

Quality Fee-For-Service
Drug Utilization and Review
PO Box 45506
Olympia WA 98504-5506
Fax (360) 586-5299

Where do I call if I have questions regarding...

Policy, payments, denials, general questions regarding claims processing, or to request billing instructions?

**Provider Relations Unit
1-800-562-6188**

Private insurance or third-party liability, other than Healthy Options?

**Coordination of Benefits Section
1-800-562-6136**

Electronic Billing?

**(360) 753-0318
or write to:**

Electronic Billing Unit
PO Box 45512
Olympia, WA 98504-5512
(360) 725-1267

Real-time, on-line Point-of-Sale claims adjudication?

**Consultec
Technical POS Help Desk
1-800-365-4944**

To access MAA's Pharmacy Web Site

<http://maa.dshs.wa.gov>

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Definitions

This section contains definitions, abbreviations, and acronyms used in these billing instructions which relate to the Medical Assistance program.

AMAC – A computer program that ranks all multisource drugs of the same chemical composition and strength in cost priority from highest to lowest price and then automatically assigns a maximum allowable cost. The assigned cost is generally the third from the bottom unless the bottom three prices are for products by noncontractors. In this case, the computer picks the first contractor's price from the bottom.

Authorization – An official approval for action taken for, or on behalf of, an eligible Medical Assistance client. This approval is only valid if the client is eligible on the date of service.

Authorization Number - A nine-digit number assigned by MAA that identifies individual requests for services or equipment. The same authorization number is used throughout the history of the request, whether it is approved, pending, or denied.

Authorized Prescriber - A physician, osteopath, osteopathic physician/surgeon, dentist, nurse, physician assistant, optometrist, pharmacist, or other person duly authorized by law or rule in the State of Washington to prescribe drugs.

Average Wholesale Price (AWP) - The average wholesale price of a drug product from wholesalers nationwide at a point in time. MAA uses the AWP as reported by a drug file pricing contractor.

Brand Name - The proprietary or trade name selected by the manufacturer and placed upon a drug, its container, label, or wrapping at the time of packaging.

Bulk Drug Delivery System - The method in which the prescribed amount of a drug product is packaged and dispensed to the patient in one bulk container.

Categorically Needy Program - A program providing maximum benefits to persons whom qualify for Medical Assistance.

Client - An applicant for, or recipient of, DSHS medical care programs.

Code of Federal Regulations (CFR) - A codification of the general and permanent rules published in the federal register by the executive departments and agencies of the federal government.

Community Services Office (CSO) - Field offices of DSHS located in communities throughout the state which administer various services of the department at the community level.

Compliance Packaging – Reusable, nonreusable drug packaging containers (e.g., Mediset, bingo cards, blister packs).

Compounding - The act of combining two or more active ingredients or adjusting therapeutic strengths in the preparation of a prescription.

Contract Drugs - Drugs manufactured or distributed by manufacturers/labelers who have signed a drug rebate agreement with the federal Department of Health and Human Services (DHHS).

Core Provider Agreement - A basic contract that MAA holds with medical providers serving MAA clients. The provider agreement outlines and defines terms of participation in the Medical Assistance program.

Covered Outpatient Drug - A drug approved for safety and effectiveness as a prescription drug under the federal Food, Drug, and Cosmetic Act, which is used for a medically accepted indication.

Deductible - An initial specified amount that is the responsibility of the client.

- (a) `Part A of Medicare - inpatient hospital deductible means an initial amount of the medical care cost in each benefit period which Medicare does not pay.
- (b) `Part B of Medicare - physician deductible' means an initial amount of Medicare Part B covered expenses in each calendar year which Medicare does not pay.

Department - The state Department of Social and Health Services (DSHS).

DESI (Drug Efficacy Study Index – or “less than effective drugs”) This is an index that measures one drug against a clinical response criteria. If the index is low, the drug is classified as less than effective.

Dispense - The interpretation of a prescription or order for a legend drug and, pursuant to that prescription or order, the proper selection, measuring, compounding, labeling, or packaging necessary to prepare that prescription or order for delivery.

Dispensing Fee - A fee set by MAA to reimburse pharmacies for their administrative costs incurred in filling prescriptions for medical assistance clients.

Drug Formulary - A list of outpatient drugs not requiring authorization, except as listed in the prior authorization section, as developed by an appropriate committee or the Drug Utilization Review (DUR) board.

Drug Utilization Review (DUR)

Program - A quality assurance program for covered outpatient drugs which assures that prescriptions are appropriate, medically necessary, and not likely to result in adverse medical outcomes.

Emergency Kit - A set of emergency pharmaceuticals furnished to a nursing facility by the primary pharmacy that provides prescription dispensing services to that facility. Each kit is specifically set up to meet the needs of the individual nursing facility.

Estimated Acquisition Cost (EAC) - The department's best estimate of the price providers generally and currently pay for a drug marketed or sold by a particular manufacturer or labeler in the package size most frequently purchased by providers.

Expedited Prior Authorization - The process for authorizing selected drugs in which providers use a set of numeric codes to indicate to the department which acceptable indications/conditions/diagnoses/criteria are applicable to a particular request for drug authorization.

Explanation of Benefits (EOB) - A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

Explanation of Medicare Benefits (EOMB) - A federal report generated by Medicare for its providers that displays transaction information regarding Medicare claims processing and payments.

Generic Code Number (GCN) Sequence Number - A number MAA uses regardless of manufacturer or package size to identify the generic formulation of a drug.

Generic Name - The official title of a drug or drug ingredients published in the latest edition of a nationally recognized pharmacopoeia or formulary.

Health Services Quality Support, Division of (DHSQS) - A division within the Medical Assistance Administration responsible for the administration of the quality improvement and assurance programs, utilization review and management, and prior authorization for fee-for-service programs.

Labeling - All labels and other written, printed, or graphic matter upon any article or any of its containers or wrappers, or accompanying such article.

Legend or Prescription Drugs - Any drugs required by any applicable federal or state law or regulation to be dispensed by prescription only or which are restricted to use by practitioners only.

Less Than Effective Drugs - See DESI.

Long-Term Therapy - Treatment a client receives, or will receive, continuously through and beyond 90 days.

Managed Care - A comprehensive system of medical and health care delivery including preventive, primary, specialty, and ancillary services. Managed care involves having clients enrolled:

- With or assigned to a primary care provider;
- With or assigned to a plan; or
- With an independent provider, who is responsible for arranging or delivering all contracted medical care.

Maximum Allowable - The maximum dollar amount a provider may be reimbursed by MAA for specific services, supplies, or equipment.

Maximum Allowable Cost (MAC)

Program - The maximum amount that MAA will pay for a specified dosage form and strength of a multiple source drug product.

Medicaid - The federal aid Title XIX program under which medical care is provided to:

- Categorically needy as defined in WAC 388-503-0310 and 388-503-1105; or
- Medically needy as defined in WAC 388-503-0320. (WAC 388-500-0005)

Medical Assistance - The federal aid Title XIX program under which medical care is provided to the categorically needy as defined in WAC 388-503-0310 and 388-503-1105.

Medical Assistance Administration

(MAA) - The unit, within the Department of Social and Health Services, authorized to administer the Title XIX Medicaid and the state-funded medical care programs.

Medically Accepted Indication - Any use for a covered outpatient drug which is approved under the Federal Food, Drug, and Cosmetic Act, which appears in peer-reviewed medical literature or which is accepted by one or more of the following compendia:

- (a) The American Hospital Formulary Service Drug Information;
- (b) The American Medical Association Drug Evaluations; or
- (c) The United States Pharmacopoeia Drug Information.

Medical Practitioner - A person licensed by the state to practice medicine, or to practice osteopathy and surgery, and who is registered with the Drug Enforcement Administration to prescribe controlled substances.

The term shall also include:

- A physician's assistant approved by the state;
- An advanced registered nurse or specialized registered nurse with an appropriate specialty licensed and approved by the state; or
- An osteopathic physician's assistant approved by the state, when practicing within the limits of their profession and under the supervision of a physician or osteopathic physician and surgeon who is registered by the Drug Enforcement Administration to prescribe controlled substances.

Medically Necessary - A term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all.

Medicare - The federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the Social Security Act. Medicare has two parts:

- “Part A” covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.
- “Part B” is the supplementary medical insurance benefit (SMIB) covering the Medicare doctor's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of Medicare. (WAC 388-500-0005)

Modified Unit Dose Delivery System – (also known as blister packs, bingo/punch cards) A method in which each patient's medication is delivered in individually sealed, single-dose packages or "blisters," usually on one card, in quantities for one month's supply, unless short-term therapy is specified by the prescriber.

Multiple Source Drug - A drug marketed or sold by two or more manufacturers or labelers or a drug marketed or sold by the same manufacturer or labeler under two or more different proprietary names or both under a proprietary name.

NABP – National Association of Boards of Pharmacies.

National Drug Code (NDC) - An 11-digit number the manufacturer assigns to a pharmaceutical product and attaches to the product container at the time of packaging that identifies the product's manufacturer, dose form and strength, and package size.

Noncontract Drugs - Drugs manufactured or distributed by manufacturers/labelers who have not signed a drug rebate agreement with the federal Department of Health and Human Services (DHHS).

Nonlegend or Nonprescription Drugs (over-the-counter) – Any drug which may be lawfully sold without a prescription.

Obsolete Drug – A drug that has been identified as obsolete by the manufacturer and is no longer available.

Obsolete NDC – A national drug code replaced or discontinued by the manufacturer or labeler.

Over-the-Counter (OTC) Drug – Drugs (nonlegend) that do not require a prescription before they can be dispensed.

Patient Identification Code (PIC) - An alphanumeric code that is assigned to each Medicaid client and which consists of:

- a) First and middle initials (or a dash (-) must be entered if the middle initial is not indicated).
- b) Six-digit birthdate, consisting of *numerals only* (MMDDYY).
- c) First five letters of the last name (and spaces if the name is fewer than five letters).
- d) Alpha or numeric character (tiebreaker).

Pharmaceutical Alternatives - Drug products are considered pharmaceutical alternatives if they contain the same therapeutic moiety, but are different salts, esters, or complexes of that moiety, or are different dosage forms or strengths...(FDA Approved Drug Products with Equivalence Evaluations, 12th Edition, 1992.)

Pharmaceutical Equivalents - Drug products are considered pharmaceutical equivalents if they contain the same active ingredient(s), are of the same dosage form and are identical in strength or concentration, and route of administration,...but they may differ in characteristics such as shape, scoring configuration, packaging, excipients (including colors, flavors, preservatives), expiration time, and within certain limits, labeling. (FDA Approved Drug Products with Equivalence Evaluations, 12th Edition, 1992.)

Pharmacist - A person duly licensed by the Washington State Board of Pharmacy to engage in the practice of pharmacy.

Pharmacy - Every site properly licensed by the Board of Pharmacy in which the practice of pharmacy is conducted.

Point-of-Sale (POS) - A pharmacy claims processing system capable of adjudicating claims on-line.

Prescription - An order for drugs or devices issued by a practitioner duly authorized by law or rule in the State of Washington to prescribe drugs or devices in the course of his or her professional practice for a legitimate medical purpose.

Prospective Drug Use Review (Pro-DUR)

A process in which a request for a drug product for a particular patient is screened for potential drug therapy problems, before the drug is dispensed.

Provider or Provider of Service - An institution, agency, or person:

- 1) Having a signed agreement with the department to furnish medical care and goods and/or services to clients; and
- 2) Eligible to receive payment from the department. (WAC 388-500-0005)

Provider Number – Number issued by MAA for reimbursement.

Program Support, Division of (DPS) - The division within the Medical Assistance Administration which processes claims for payment under the Title XIX (federal) program and state-funded programs.

Reconstituted Drug – The process of returning a substance, previously altered for preservation and storage, to its approximate original state. (For purposes of reimbursement, this definition does not apply to pediatric antibiotic powders contained in plastic bottles.)

Remittance And Status Report (RA) - A report produced by the claims processing system in the Division of Program Support, Medical Assistance Administration that provides detailed information concerning submitted claims and other financial transactions.

Retrospective Drug Use Review (Retro-DUR) - The process in which drug utilization by patients is reviewed on a periodic basis to identify patterns of fraud, abuse, gross overuse, or inappropriate or unnecessary care.

Revised Code of Washington (RCW) - Washington State laws.

Single Source Drug - A drug produced or distributed under an original new drug application approved by the FDA, including a drug product marketed by any cross-licensed producers or distributors operating under the new drug application.

Terminated Drug Product - A product whose shelf life expiration date has been met, per manufacturer notification.

Therapeutically Equivalent - Essentially the same efficacy and toxicity when administered to an individual in the same dosage regimen.

Third Party - Any entity that is or may be liable to pay all or part of the medical cost of care of a federal Medicaid or state medical care client. (WAC 388-500-0005)

Trade Container (Trade Unit) - The smallest self-contained package (unbreakable) as provided by the labeler/distributor. For example, the product may only be purchased in cases of 12 bottles of 100 tablets each, but the smallest unbreakable container is a bottle of 100 tablets.

True Unit Dose Delivery - A drug delivery system in which each patient's medication is delivered to the nursing facility daily in quantities sufficient only for the day's required dosage.

Usual & Customary Fee - The fee that the provider usually charges his or her non-Medicaid customers for a service or item. This is the maximum amount that the provider may bill MAA for the same service or item.

Washington Administrative Code (WAC) - Codified rules of the State of Washington.

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Drug Program

What is the goal of the Prescription Drug Program?

The goal of the Prescription Drug Program is to provide quality pharmaceuticals and pharmacist services to clients served by the Medical Assistance Administration (MAA). This program is governed by federal regulations and provides coverage for pharmaceuticals manufactured by companies who have signed a Federal Rebate Agreement.

This may entail:

- Placing the drug onto the Drug Formulary;
- Requiring that the drug be prior authorized; or
- Not covering certain drugs.

The specific details are included in these instructions.

It is MAA's goal to assist the prescriber, the pharmacy, and the client with well coordinated services.

Who may prescribe, administer, or dispense legend drugs and controlled substances?

Primary authority for the prescribing of legend drugs and controlled substances comes from individual professional practice acts, usually in the section of the act which defines the scope of practice for the profession. The definition of scope of practice is the responsibility of the board that licenses the professional.

The Legend Drug Act (69.41.030 RCW) and the Uniform Controlled Substances Act (69.50.101 RCW) each define which practitioners may prescribe these drugs.

For the purposes of MAA's Prescription Drug Program, the practitioners listed in the table below, when properly licensed and registered under the Uniform Controlled Substances Act, **may prescribe, administer, or dispense legend drugs and controlled substances.**

PROFESSION	RESTRICTION	LAW/RULE
Physician (MD)	None	18.71 RCW
Osteopathic Physician and Surgeon (DO)	None	18.57 RCW
Dentist (DDS or DMD)	Dental practice	17.32.685 RCW only
Podiatric Physician (DPM)	Podiatry practice	18.22.185 RCW only
Advanced Registered Nurse Practitioner (ARNP)	Scope of practice	18.88.280 RCW
Medical Physician Assistant (PA)	No Schedule II	18.71 RCW/WAC 308-52
Osteopathic Physician Assistant (PA)	No Schedule II	18.57A RCW/WAC 308-138A
Optometrist (OD)	Topical Eye Drugs only	18.53.010 RCW/WAC 308-53
Pharmacist (RPh)	Scope of Practice	18.64.005 RCW/ WAC 246-863-100

Guidelines for completing prescription forms which will be filled by a pharmacist:

1. Complete all sections of the prescription form.
2. Be sure to sign the form and include all necessary identification numbers.
3. Make your instructions as clear and legible as possible.
4. Make every effort to select a drug from the Drug Formulary list which does not require prior authorization (see green pages). Use this whenever possible to avoid delays and possible denial of prior authorization requests.
5. Allow generic substitution whenever possible.
6. Specify the quantity to be dispensed.
7. Indicate if the client resides in a nursing facility.
8. Indicate the number of authorized refills.
9. Indicate the expedited prior authorization code for the prescribed drug on the prescription when applicable, or specify medical justification if non-formulary or not expedited.
10. Indicate your DSHS prescriber (provider) number.

National Association of Boards of Pharmacy (NABP) Number

- All claims must contain the NABP number.
- Do not use the 7-digit provider number assigned to you by the Medical Assistance Administration (MAA) for claims submission. However, MAA's assigned provider number will appear on your Remittance and Status Reports.
- Paper and electronic claim submitters should enter the NABP number where MAA's provider number was previously entered.

Billing a Medical Assistance Client (WAC 388-87-010)

- A. A provider may bill a client for non-covered services only when:
1. The client received reimbursement directly from a third party for services that the department had no payment responsibility for; or
 2. The client refuses to execute legal signature on insurance forms, billing documents, or other forms necessary to receive insurance payments for services rendered during a period of eligibility; or
 3. The claim counts toward a spend-down liability or emergency medical expense requirement; or
 4. The client signs a specific written agreement with the provider before receiving the service(s) or item(s) and the agreement states:
 - The name of the specific service(s) or item(s) provided;
 - The service or item is neither covered by the Medical Assistance program nor reimbursed as part of another service;
 - The client chooses to receive the specific service; and
 - The client agrees to pay for the service.

The agreement is void and unenforceable and the client is under no obligation to pay if the provider fails to adhere to B.

- B. The client is under no obligation to pay the provider if the provider fails to do any of the following:
- Determine client eligibility.
 - Obtain prior authorization from MAA when it is required.
 - Provide claims to MAA within MAA's billing time limit.
 - Submit a complete claim according to MAA's billing instructions.
 - Pursue third-party liability, when necessary, within MAA's billing time limit/insurance carrier filing limits.
 - Provide adequate documentation of medical necessity.
 - Make sure the Medical Assistance program that the client is eligible for covers the service or item being provided.
 - Obtain a managed care provider referral for non-emergent services provided to a managed care client; or
 - Investigate system edits such as *refill too soon*, *exceeds plan limitations*, or *duplicate therapy*.

Abuse and Misutilization

The following practices constitute abuse and misutilization:

- A. Excessive Fees (commonly known as *prescription splitting* or *incorrect or excessive dispensing fees*): Billing inappropriately in order to obtain dispensing fees in excess of those allowed by:
- Supplying medication in amounts less than necessary to cover the period of the prescription; **and/or**
 - Supplying multiple medications in strengths less than those prescribed to gain more than one dispensing fee.
- B. Excessive Filling: Excessive filling consists of billing for an amount of a drug or supply greater than the prescribed quantity **except** when a mandatory amount in excess of the quantity prescribed is specified by MAA.
- C. Prescription Shorting: Billing for drug or supply greater than the quantity actually dispensed.
- D. Substitution to Achieve a Higher Price: Billing for a higher priced drug than prescribed even though the prescribed lower priced drug *was* available.

Client Eligibility

Types of identification that prove eligibility

There are five types of valid identification that can be used to identify medical programs for which he/she is eligible:

- A white medical assistance ID (MAID) card with green print, issued monthly by the Department of Social and Health Services (DSHS);
- A yellow MAID card with brown print, issued by the community services office (CSO);
- A printout of a medical identification screen from the client's local CSO. To be valid, the printout must be notarized or marked by the CSO with a stamp identifying the location of the CSO;
- An award letter from the CSO; or
- Medical eligibility verification (MEV) provided by an authorized MEV vendor.

The CSO computer printout or award letter can be used as valid identification since both list the eligibility information that appears on the client's DSHS MAID card. If a client presents a CSO printout that does not have an official stamp on it, it is not valid identification.

- MAA recommends you make a photocopy of valid identification for your file when it is presented to you.

Review the eligibility verification for the following information:

- Beginning and ending eligibility dates
- The Patient Identification Code (PIC)
- Other specific information (e.g., Medicare, private insurance, or Managed Care coverage, Hospice, Patient Requiring Regulation, etc.)
- Retroactive or delayed certification eligibility dates, if any.

Who is eligible?

Clients presenting medical assistance ID (MAID) cards with the following identifiers are eligible for the Prescription Drug Program:

- **Children's Health**
- **CNP or CN**
- **CNP-QMB**
- **GAU (W) – No Out of State Care**
- **LCP-MNP**
- **MNP-QMB**
- **Family Planning Only** (Limited Coverage)

Who is not eligible?

Clients presenting MAID cards with the following identifiers are not eligible for the MAA Prescription Drug Program:

- **Emergency Hospital and Ambulance Only** (Medically Indigent)
- **QMB Medicare Only**

Note: If you provide services to a person who is *not* eligible for a Medical Assistance program at the time of service, and who is later determined to be eligible, you may be paid by MAA when:

- The service is determined to be medically necessary;
- The service is covered by MAA;
- The service is within the scope of care of the medical program for which the client is eligible;
- The client provides you with a medical assistance ID (MAID) card covering the date of service and indicating retroactive or delayed certification; and
- Your claim is presented within 365 days from the *retroactive*¹ or *delayed certification*² date.

1 Retroactive Certification: An applicant receives a service, then applies to MAA for medical assistance at a later date. Upon approval of the application, the person was found to be eligible for the medical services at the time he or she received the service. The provider **MAY** refund payment made by the client and then bill MAA for these services.

2 Delayed Certification: A person applies for a medical program prior to the month of service and a delay occurs in the processing of the application. Because of this delay, the eligibility determination date becomes later than the month of service. A delayed certification identifier will appear on the MAID card. The provider **MUST** refund any payment(s) received from the client for the period he/she is determined to be Medicaid-eligible, and then bill MAA for those services.

The Point of Sale (POS) system does not solve the problem of identifying clients who are not currently on MAA's eligibility file. For clients whose MAID cards show that they are eligible, but their claims deny in the POS system for lack of eligibility, please take the following steps:

- **FAX** a copy of the MAID card to Claims Entry at (360) 586-1403; or
- Mail in a **completed** paper claim with a photocopy of the MAID card attached.

Faxed copies of MAID cards will be updated within 48 hours in order for claims to be resubmitted. Please do not fax **claims** to this number.

"Restricted" Clients

Clients who use medical services excessively or inappropriately are assigned to the MAA Patient Requiring Regulation (PRR) program. The purpose of this program is to assist clients in using medical services appropriately. If a client is assigned to this program, there will be an X in the **Restricted** column and "Client on Review" will be printed in the **Other Messages** area of the medical assistance ID (MAID) card.

These clients must select a primary physician and pharmacy to provide them with their medical services. Payment for services rendered by any physician or pharmacy other than the primary physician or pharmacy will be denied except in cases of emergency or referral by the designated physician.

Services provided by the following providers are **not** subject to restriction by the PRR program:

Dentists	Medical Transportation Services
Drug Treatment Facilities	Mental Health Facilities
Emergency Medical Services	Optometrists
Family Planning Agencies	Other Medical Providers
Home Health Agencies	(e.g., Durable Medical Equipment)
Hospitals	

**If you have questions about the PRR program or wish
to report a client for utilization review call
(360) 753-2512.**

Hospice Clients

Clients who have elected to receive hospice benefits are identified by an **X** in the hospice area on their medical assistance ID (MAID) card.

Clients enrolled in the Hospice program **waive** services outside the Hospice program that are directly related to their terminal illness. All services related to their terminal illness must be coordinated and provided by the designated hospice agency and attending physician **only**.

Services **not** related to the terminal illness may be provided to clients on a fee-for-service basis. When billing for hospice clients and the service is **not** related to the terminal illness, use the following billing procedures:

Hard copy billers must enter a "K" in the *Justification/Comments* area on the Pharmacy State claim form.

Electronic billers must enter a "K" as follows:

Tape format.....in the 46th position of the HD record
 EMC formatin the 54th position of the HD record
 Multi-insurer formatin the 79th position of the P3 record

Point-of-Sale billers: See Point-of-Sale section.

What about managed care clients?

An identifier in the Health Maintenance Organization (HMO) column on their medical assistance ID (MAID) card indicates that the client is enrolled in a Healthy Options managed health care plan. These clients **are eligible** for pharmacy services under their designated plan.

When a mother is enrolled with a Healthy Options managed health care plan at the time of delivery, the newborn is also covered under the plan.

MAA will reimburse for drugs dispensed to Healthy Options managed health care plan enrollees only if the drugs are provided outside the scope of the managed care plan.

Examples:

- Prescriptions written by **dentists** will be paid fee-for-service without any special comments when the dentist's performing provider number is placed on the claim in the prescriber ID field.
- Antibiotics, anti-infectives, non-narcotic analgesics, and oxytocics prescribed following abortion procedure are reimbursable on a fee-for-service basis for clients enrolled in a Healthy Options managed health care plan.
- Over-the-counter contraceptives from a non-plan contracted pharmacy.
- Protease Inhibitors.

Healthy Options Clients Who Self Refer

Healthy Options managed care clients may self-refer to any of the following entities and receive prescriptions related to the therapeutic classifications listed below. The prescriptions are reimbursable on a fee-for-service basis and, clients may take these prescriptions to any Medicaid-participating pharmacy.

Pharmacists must document the prescribing entity (e.g., mental health center) on the original prescription. All other fee-for-service rules apply to claims for the therapeutic classes listed below, including prior authorization requirements.

Community Mental Health Centers may prescribe mental health drugs within the following therapeutic drug classes:

Attention Deficit Hyperactive Disorder (ADHD) drugs (e.g., Cylert, Methylphenidate)
Antianxiety
Anticonvulsants
Antidepressants
Antipsychotics
Central Nervous System (CNS) drugs

Pharmacies may bill MAA for selected ancillary drugs used as an integral part of the total mental health therapy when prescribed by a Community Mental Health Center. These drugs may be prescribed in addition to the therapeutic classes listed above.

The following is a list of Community Mental Health ancillary drugs. Any strength or dose form not listed below will not be covered under these provisions.

Akineton 2 mg tab

Amantadine 100 mg caps and 50 mg/5 ml liquid

Atenolol 25 mg, 50 mg, and 100 mg tabs

Benzotropine mesylate 0.5mg, 1mg, 2mg tabs

Carbamazepine 100mg chew tab or 200mg tab

Clonazepam 0.5mg, 1.0mg, and 2mg tabs

Clonidine 0.1 mg, 0.2mg, and 0.3mg tabs (no patches)

Cytomel (T4) 5mcg, 25mcg, and 50mcg tabs

Depakote 125mg and 250mg tabs

Diphenhydramine 25mg and 50 mg caps

Guanfacine 1mg and 2mg tabs

Hydroxyzine Pamoate 25mg caps, 25mg/ml, 50mg caps, 50mg/ml, 100mg caps

Kemadrin 5mg tab

L-Thyroxine all strengths

Nadolol 20mg, 40mg, 80mg, 120mg, and 160mg tabs (no sustained action – SA)

Neurontin 100mg, 300mg, and 400mg caps

Pindolol 5mg and 10mg tabs

Propranolol 10mg, 20mg, 40mg, 60mg, 80mg, and 90mg tabs (no sustained action – SA)

Tegretol 100 mg chew tab, 100mg/5ml, or 200mg tab

Trihexyphenidyl 2mg tabs, 5mg, SA, and tabs

Vitamin E (expedited prior authorization only for Tardive Dyskensia)

Family Planning Agencies may prescribe sexually transmitted disease (STD) drugs (excluding HIV drugs), abortion-related drugs and prescription contraceptives within the following therapeutic drug classes:

Analgesics

Antibiotics

Anti-emetics (refer to list on page B.7)

Anti-infectives

Anti-inflammatories

Contraceptive drugs/devices

Oxytocics

Health Departments may prescribe STD drugs (excluding HIV drugs), tuberculosis drugs, and prescription contraceptives within the following therapeutic drug classes:

Antibiotics

Anti-emetics (refer to list on page B.7)

Anti-infectives

Contraceptive drugs/devices

Tuberculosis drugs

Billing for one of the previously listed drugs for managed care clients who have self-referred outside of the plan:

Hard copy billers must enter one of the following comments in the *Justification/Comments* field on the Pharmacy Statement claim form:

Prescribed by Family Planning Agency
Prescribed by Community Mental Health Center; OR
Prescribed by Health Department

Electronic billers must enter an **X** as follows:

Tape formatin the 46th position of the HD record
EMC format.....in the 54th position of the HD record
Multi-insurer formatin the 79th position of the P3 record

Point-of-Sale billers – See Point-of-Sale section.

Family Planning Only Clients

Pharmacies may bill for selected anti-emetics only when these drugs are dispensed in conjunction with emergency contraceptive pills. MAA will reimburse the following only when they are prescribed and dispensed in the strength/dose form listed:

Meclizine hydrochloride	25 mg tablets
Diphenhydramine hydrochloride	25 mg tablets/capsules
Dimenhydrinate	50 mg tablets
Trimethobenzamide hydrochloride	250 mg capsules or 200 mg suppository
Promethazine hydrochloride	25 mg tablets or 25 mg suppository
Metoclopramide	5 mg, 10 mg tablets
Prochlorperazine	25 mg suppository

Third Party Liability

Clients with privately purchased HMO insurance will have an **HI, HO, or HM** identifiers in the insurance column on their medical assistance ID (MAID) card. These clients are required to use the HMO facilities for their medical services (including pharmacy). If services are provided that are not covered by the HMO plan, the claim may be submitted to MAA for processing without first billing the HMO to receive a denial from them. Enter "Not covered by HMO" in the *Comments* section on the Pharmacy Statement claim form. The pharmacy must maintain documentation of the non-HMO coverage.

The carrier code information is available on the DSHS/MAA website at <http://maa.dshs.wa.gov>. The information can be downloaded and printed, or used as an on-line reference.

For questions related to insurance, please call:

Coordination of Benefits Hotline
1-800-562-6136
or write:
Coordination of Benefits Program
Division of Client Support
PO Box 45565
Olympia, WA 98504-5565

Pharmacy providers who submit their claims through the on-line POS system are not required to submit third party EOB documents. However, documentation must be kept for audit purposes. Listed below are some specific third party situations and how they would be processed in the POS system.

- Balance Billing** - This is necessary when partial payment is received from the primary payor and the "balance" is billed to MAA. The usual and customary charge applicable to any customer with the same insurance (third party "Allowed Amount") must be entered in the *Usual and Customary* field and in the *Gross Amount Due* field. The balance due must not exceed the third party's determined *Patient Responsibility Amount*. The insurance payment amount must be entered in the *Other Payor Amount* field. When a third party payment is reported, there is no need for an entry in the *Other Coverage Code* field. Please leave the *Other Coverage Code* field blank in this instance.

Note: In this instance, the normal 34-day supply limit may be exceeded.

- **Capitated Contracted Situations** – This is for capitated service copayments only (no fee-for-service payment is applicable to the claim under any circumstances by the primary payor). The copay amount (the primary payor determined "Patient Responsibility Amount") will appear in the *Usual and Customary* field and in the *Gross Amount Due* field. The *Other Payor Amount* field will be a zero (no fee-for-service payment connected to this service). Enter a "2" in the *Other Coverage Code* field. A capitated service copayment is the only type of claim where a "2" is used. By entering a "2," the service provider is certifying that no fee-for-service payment is applicable to the claim by the primary payor.

Note: *In this instance, the normal 34-day supply limit may be exceeded.*

- **Insurance Denials and "Paid at \$0" Claims** - These claims are necessary when you bill the insurance carrier and receive a denial or you are "Paid at \$0." Payment at \$0 occurs when the primary payor has applied a claim, in total, to a deductible or other coinsurance condition. Enter a "3" in the *Other Coverage* field and the date the claim was denied (or processed at \$0) in the *Primary Payor Denial Date* field. In the case of a "Paid at \$0" claim, enter the primary payor's determined allowed amount in the *Usual and Customary Amount* field and the *Gross Amount Due* field. If no "Allowed Amount" has been established by the primary payor, enter your usual and customary charge level in the *Usual and Customary Amount* field and the *Gross Amount Due* field.
- **POS Primary Insurance Billing Exceptions:** - Situations may arise when a client is out of the HMO service area or HMO coverage is not accessible. After making reasonable attempts at accessing the primary coverage, a pharmacy provider may proceed to meet the client's immediate needs.

An exception to regular POS insurance billing requirements is allowed for Medicaid clients whose insurance company requires the client to pay before receiving prescriptions. To enable those clients to receive their medications, MAA will pay the lesser of your billed amount or the Medicaid maximum allowable. Bill MAA, not the client's insurance.

In these instances, enter a "4" in the *Other Coverage Code* field to bypass the POS/TPL edit. Enter the usual and customary amount in the *Usual and Customary* field and the *Gross Amount Due* field. Although all claims are subject to audit, post payment audit and review will be conducted on these conditions. Services not meeting the stated criteria may have their payments recouped by MAA.

If you do not submit your claim through the on-line POS system and the claim requires attachments, **you must bill the claim hardcopy.**

Medicare/Medicaid Benefits Coordination

Some Medicaid clients are also eligible for Medicare benefits. Benefits under Part B Medicare now cover some drugs and related supplies. When you have a client who is eligible for both Medicaid *and* Medicare benefits, you should submit claims for that client to your Medicare intermediary or carrier, *first*. Medicare is the primary payor of claims.

MAA cannot make direct payments to clients to cover the deductible and/or coinsurance amount of Part B Medicare. MAA *can* pay these costs to the provider on behalf of the client when: (1) the provider accepts assignment, and (2) the total combined reimbursement to the provider from Medicare and Medicaid does not exceed Medicare's allowed amount. MAA will pay up to Medicare's allowable or MAA's allowable, whichever is less.

An **X** in the *Medicare* area on the client's medical assistance ID card (area 9) indicates Medicare eligibility.

QMB (Qualified Medicare Beneficiaries Program Limitations):

Qualified Medicare Beneficiaries (MNP-QMB)

If the service you provide is covered by Medicare *and* Medicaid, MAA will pay the lesser of

- the full coinsurance and deductible amounts due, based upon the Medicare allowed amount, or
- the department's maximum allowable fee for that service minus the amount paid by Medicare.

Qualified Medicare Beneficiaries (QMB-MEDICARE Only)

The reimbursement criteria for this program are as follows:

- If the service is covered by Medicare **and** Medicaid, MAA pays the deductible and/or coinsurance up to Medicaid's allowed amount.
- If the service is covered only by Medicare and *not* Medicaid, MAA pays the deductible and/or coinsurance up to Medicare's allowed amount.
- If the service is not covered or denied by Medicare, MAA **does not** reimburse.

After Medicare has processed your claim, and if Medicare has allowed the services, in most cases Medicare will forward the claim to MAA for any supplemental Medicaid payment. When the words, *"This information is being sent to either a private insurer or Medicaid fiscal agent,"* appear on your Medicare remittance notice, it means that your claim has been forwarded to MAA or a private insurer.

- If **Medicare has paid** and the Medicare crossover claim does not appear on the MAA Remittance and Status Report within 30 days of the Medicare statement date, bill MAA using the HCFA-1500 claim form.
- If **Medicare denies** a service, bill MAA using the Pharmacy Statement form. Be sure the Medicare denial letter or EOMB is attached to your claim to avoid delayed or denied payment due to late submission. Claims may also be billed on the Point-of-Sale (POS) system using the appropriate DUR outcome code, if applicable (see section K). **NOTE:** When Medicare denies a service that requires prior authorization, MAA waives the *prior* requirement, but authorization is **still required**.

For services requiring authorization, call:

DRUG UTILIZATION AND REVIEW
1-800-848-2842

**You must submit your claim to MAA within
six months of the Medicare statement date.**

**Do not bill MAA for Medicare's coinsurance and deductible
through the on-line POS system.
For detailed billing instructions, see Section I.**

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Coverage/ Program Limitations

What drugs and pharmaceutical supplies are covered?

The Medical Assistance Administration (MAA) will reimburse for:

1. Outpatient legend drugs.
2. Over-the-counter (OTC) drugs when the drug is:
 - Prescribed; **and**
 - A less costly therapeutic alternative; **and**
 - Formulary.
3. Compounded prescriptions.
4. Non-formulary drugs when prior authorized by the department.
5. Family planning supplies used in conjunction with family planning, including OTC supplies. Covered family planning OTC supplies include, but are not limited to, hormonal contraceptives, spermicidal contraceptives and barrier contraceptives.
6. Oral, topical and/or injectable drugs, vaccines for immunizations, and biologicals, prepared or packaged for individual use and dispensed or administered to a client by an authorized provider.
7. Diabetic supplies such as insulin syringes and needles, blood/urine test strips and tape, lancets and lancet devices, glucose monitor control solutions.

What drugs and pharmaceutical supplies are not covered?

The Medical Assistance Administration (MAA) does not reimburse for the followings items or services:

1. Drugs supplied by drug manufacturers who have **not** entered into a drug rebate agreement. Exceptions are listed in the Drug Rebate section of these billing instructions.
2. Drugs regularly supplied as an integral part of program activity by other public agencies such as the United States Veteran's Administration, United States Department of Health and Human Services, Indian Health Services, local health departments, etc.
3. Drugs prescribed:
 - For weight loss or gain.
 - To promote fertility, treat impotence or frigidity.
 - For cosmetic purposes or hair growth.
 - To promote smoking cessation; or
 - For an indication which is not medically accepted as determined by MAA in consultation with federal guidelines, the Drug Utilization Education Council (DUEC), and MAA medical and pharmacy consultants.
4. Over-the-counter (OTC) drugs/supplies requested solely by the client. (When prescribed by a licensed prescribing authority, prior MAA authorization may be required.) (See OTC list.)

Exceptions:

- Condoms (including female condoms), vaginal spermicidal foam with applicator and refills, vaginal jelly (with applicator), vaginal contraceptive sponge, vaginal contraceptive film, and vaginal suppositories.
5. Drugs listed in the federal register as “less-than-effective” (“DESI” drugs) or which are identical, similar, or related to such drugs. (See Less-Than-Effective Drug Index section.)
 6. Prescription vitamins and mineral products in the absence of a condition that is clinically documented to produce a deficiency state, except prenatal vitamins and fluoride preparations. Prenatal vitamins are covered **only** when prescribed and dispensed to pregnant women. Fluoride preparations are covered only for children, under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT or “Healthy Kids”) services.

7. Drugs that are experimental, investigational, or of unproven efficacy or safety.
8. Preservatives, flavoring, and/or coloring agents used in the process of compounding.
9. Prescriptions written on pre-signed prescription blanks filled out by nursing facility operators or pharmacists.
10. Drugs used to replace those taken from nursing facility emergency kits.
11. Free pharmaceutical samples.
12. Obsolete National Drug Code (NDC)
13. Terminated drug products.
14. Any drug, biological product, or insulin provided as part of, or incident to and in the same setting as, any of the following:
 - Inpatient hospital setting.
 - Hospice services.
 - Dental services, except as authorized under the state plan.
 - Physician's services.
 - Outpatient hospital services emergency room visit.
 - Other laboratory and x-ray services; or
 - Renal dialysis.
15. Any of the following drugs:
 - Outpatient nonprescription drugs.
 - Covered outpatient drugs for which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee.
16. Medical supplies (non-drug items) are not covered under the prescription drug program.

Exceptions:

- Contraceptive devices.
- Insulin syringes and needles.
- Blood/urine test strips and tape.
- Lancets and lancet devices; or
- Glucose monitor control solutions.

All other medical supplies should be billed to the Durable Medical Equipment or Non-Durable Equipment & Supplies Program on a HCFA-1500 claim form.

Is there a “Days Supply” limit?

Most drugs are limited to a 34-day supply, except:

Dispensed in quantities of 100	Dispensed in quantities of 200	Dispensed in 3-month supply
Ammonium Chloride tablets	Acetaminophen	Polyvitamin drops w/fluoride
Antacid tablets	Aspirin	
Calcium Carbonate tablets	<p>Dispensed for a 90-day supply:</p> <ul style="list-style-type: none"> Estring 2mg Vaginal Ring <p>Dispensed up to a 3-month supply:</p> <ul style="list-style-type: none"> Birth control pills <p>Exceptions:</p> <ul style="list-style-type: none"> ➤ Clients receiving Nor-Q-D are limited to two (2) packets in a three-month period. ➤ One Norplant kit is allowed per client in a five-year period. 	
Calcium Gluconate tablets		
Calcium Lactate tablets		
Digoxin tablets		
Ferrous Fumarate tablets		
Ferrous Gluconate tablets		
Ferrous Sulfate tablets		
Fluoride tablets		
Lanoxin		
Niacin tablets		
Niacinamide tablets		
Nicotinic Acid tablets		
Nitroglycerin sublingual tablets		
Prenatal vitamins		

How many prescriptions are allowed per month if less than a 34-day supply is prescribed?

If less than a 34-day supply, no more than two prescriptions of the same drug are allowed in any calendar month. The third fill requires prior authorization.

Exceptions:

- Compounded prescriptions.
- Over the counter contraceptives; or
- Suicidal patients or patients at risk for potential drug abuse may be prescribed a ten (10) day supply of dangerous drugs.

Four fills in a calendar month are allowed for the following drugs (fifth fill will require authorization):

1. Antibiotics
2. Anti-asthmatics
3. Schedule II & III drugs
4. Antineoplastic agents
5. Topical preparations
6. Propoxyphene, propoxyphene napsylate, and all propoxyphene combinations.

Exceptions:

- When a patient has been on the medication longer than 90 days (the time defined as “chronic”); or
- When a physician has identified the client as chronic by the writing of the prescription in a large amount.

**The Drug Use and Education Council (DUEC)
recommends:**

Limit Monthly Amounts of Certain Drugs

Because of misuse or abuse by patients, the MAA DUE Council recommends physicians and pharmacists set monthly limits on certain drugs. The following limits are recommended:

Imitrex injection	8 units; 16 doses per month
Imitrex nasal spray	12 units
Imitrex tablets	9 tablets per month
Klonopin	Not to exceed 20 mg daily dose
Maxalt & Maxalt – MLT	12 tablets per month
MDIs	2 units per month of each type
Sedative hypnotics	34 per month when medically necessary
Stadol NS	3 to 4 vials per month; 1 vial is 15 doses
Toradol tablets	5-day supply; 10 units
Zomig tablets	9 tablets per month

Physicians and pharmacists should monitor the use of these drugs and counsel patients where the limits are exceeded.

Which drugs may be dispensed without a prescription?

The following over-the-counter contraceptives may be dispensed, without a prescription, to any MAA client with a current medical assistance ID (MAID) card:

- condoms (including female condom)
- vaginal spermicidal foam with applicator and refills
- vaginal jelly with applicator
- vaginal films
- vaginal suppositories

To receive payment, pharmacies may bill MAA fee-for-service using the product specific NDC number and prescribing provider number **9777707**. Regardless of the contraceptive, please bill the NDC as stated on the package.

Is it possible to receive early refills?

MAA denies all drug claims that are submitted for a date of service earlier than 75% of the estimated therapy days having elapsed.

The following circumstances are justification for early refills:

- If a client's prescription is lost or stolen (only once every 6 months, per medication).
- If a client needs a refill sooner than originally scheduled due to a prescriber dosage change. (The pharmacist must document the dosage change.)
- If a client is suicidal or at-risk for potential drug abuse.
- If a client needs a take home supply of medication for school or camp, or for nursing home clients.

For any other circumstance, the provider must contact MAA's Quality Fee-For-Service Section to receive approval and a medical prior authorization number (see Important Contacts section).

Pharmacy providers have the right to ask clients for documentation relating to reported theft or destruction, (e.g., fire, earthquake, etc.). If a client residing in a nursing facility has his/her prescription lost or stolen, the replacement prescription is the responsibility of the nursing facility. Clients who experience difficulties in managing their drug therapy should be considered for the use of compliance devices (e.g., Medisets).

TO BILL MAA:

Hard copy billers must enter one of the following justifications in the *Justification/Comments* area on the Pharmacy State claim form:

Hard copy

Electronic billers

"Take Home Supply (Nursing Home Patient)"	Q
"Suicidal Risk (SR)"	Q
"Lost or Stolen Drug Replacement"	S
"School or Camp"	Q
"ITA"	I

Electronic billers must enter one of the above justification identifiers in the following position, accordingly:

Tape formatin the 46th position of the HD record
 EMC format.....in the 54th position of the HD record
 Multi-insurer format.....in the 79th position of the P3 record

Point-of-Sale billers: See Point-of-Sale section.

Generic Drugs

Prescribers and pharmacies should prescribe and dispense the generic form of a drug, whenever possible. Prior authorization is required for brand name drugs when a generic equivalent is available. If the brand name drug is prescribed instead of a generic equivalent, the prescriber must provide medical justification for the use of the brand name drug to the pharmacist. Prior authorization is based on medical need such as adverse reactions (clinically demonstrated, observed and documented) which have occurred when the generic drug has been used.

Generic drugs should be substituted for listed brand name drugs when:

- They are approved by the FDA as therapeutically equivalent drugs; and
- They are permitted by the prescribing physician under current state law.

To request authorization, call the MAA drug authorization line at 1-800-848-2842.

Cost Per Milligram (mg) Savings

MAA has identified medications that, when dispensed in the lower cost per milligram form, result in cost savings. Therefore, MAA asks pharmacists to dispense the following drugs in the least costly per mg dose by: 1) splitting higher dose tablets in half; or 2) instructing clients to take two or more of a lower dose to equal the desired dosage.

Drug Name	Required Dosage	Tablet to split
Effexor	25 mg	50 mg
Effexor	37 ½ mg	75 mg
Effexor	50 mg	100 mg
H2RA's	150 mg – dispense lower mg with instructions to take two or more to equal desired dosage.	
Paxil	10 mg	20 mg
Serzone	100 mg	200 mg
Zoloft	50 mg	100 mg

Splitting Requirements

When dispensing medications listed above, exact dosing must be clearly explained and emphasized as part of client counseling. Pharmacists **must** split medications for clients.

Pharmacists are reminded of their professional obligation to inform the prescriber when changes have been made in dispensing the prescription. MAA encourages prescribers to consider this pharmacy program savings effort when writing prescriptions.

Anticipated Savings

If the above strengths of Effexor and Serzone dispensed in calendar year 1997 had used a half tablet of the higher strength, the following savings would have occurred:

Effexor - \$179,690

Serzone - \$176,070

MAA will continue to work with the pharmacy community to identify other medications to add to the list to realize additional pharmacy program savings.

Clozaril and Related Services

MAA reimburses pharmacists for Clozaril plus a dispensing fee. Bill Clozaril using the appropriate NDC on either the POS system or the 525-106 claim form.

Any licensed or registered pharmacist with clinical experience in monitoring patient mental and health status may provide and bill case coordination (medication management) for clients receiving Clozaril.

Persons providing case coordination serve as a focal point for the client's Clozaril therapy. All services must be documented and are subject to quality assurance review. Case coordinators are expected to:

- coordinate a plan of care with the client or the client's caregiver, the prescriber, and the pharmacy;
- assure services are provided to the client as specified in the plan of care;
- assure weekly blood samples are drawn, blood counts are within normal range, and client is compliant with plan of care;
- follow-up with the client on missed medical appointments;
- maintain detailed, individual client records to document progress;
- provide feedback to the prescriber on the client's progress, immediately report abnormal blood counts, and client non-compliance; and
- assure smooth transition to a new care coordinator, when necessary.

Use the following procedure codes to bill for Clozaril related services on a HCFA-1500 claim form or the appropriate electronic format:

Procedure Code	Description	Reimbursement
36415	Routine Venipuncture	per RBRVS fee schedule
0857J	Case Coordination	\$10 per week, per client
85022 ¹	Blood Count (CBC)	per RBRVS fee schedule

¹ Can be billed by CLIA certified laboratories only.

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Compliance Packaging

The Medical Assistance Administration (MAA), the Home Care Association of Washington (HCAW) and the Washington State Pharmacists Association (WSPA) developed the following guidelines in a cooperative effort to improve drug therapy outcomes for the most *"at-risk"* segment of the Medical Assistance population.

What is included in compliance packaging?

Compliance packaging includes:

- Reusable hard plastic containers of any type (e.g., Medisets, weekly minders, etc.); and
- Nonreusable compliance packaging (e.g., blister packs, bingo cards, bubble packs, etc.).

How do I determine if a client is eligible for compliance packaging?

Prescribers are encouraged to communicate to high risk clients the need for compliance packaging if, in their professional judgement, such packaging is appropriate.

Clients will be considered high risk and eligible to receive compliance devices if they:

- are **not** in a nursing facility; **and**
- have one or more of the following representative disease conditions: Alzheimer's disease, blood clotting disorders, cardiac arrhythmia, congestive heart failure, depression, diabetes, epilepsy, HIV/AIDS, hypertension, schizophrenia, or TB.

-AND-

- consume two or more prescribed chronic medications concurrently which are dosed at three or more intervals per day; **or**
- have demonstrated a pattern of noncompliance that is potentially harmful to their health.

Pharmacists pre-filling syringes are not considered compliance packaging. They may be billed as compounded drugs.

How do I bill for compliance packaging?

To bill for compliance packaging:

1. Bill on a HCFA-1500 claim form.
2. Bill your usual and customary charge. Reimbursement will be the billed charge or the maximum allowable fee, whichever is less.
3. Use the following procedure codes, as appropriate.

Procedure Description	Procedure Code	Maximum Allowable
Reusable compliance device or container	4800A*	\$6.00 maximum per device (limit of 4 per client, per year).
Reusable compliance device or container, extra large capacity	4804A*	\$16.91 maximum per device (limit of 4 per client, per year). <i>Effective with dates of service on and after October 1, 2000.</i>
Filling fee for reusable compliance device or container	4801A	\$2.50 per fill (limit of 4 fills per client, per month).
Non-reusable compliance device or container	4802A	\$3.00 (limit of 4 fees per client, per month) Includes reimbursement for materials and filling time. Bill one unit each time compliance packages are filled.

* May be billed in combination but not to exceed a total of 4 per year.

Written requests for a limitation extension should be sent to:

Division of Health Services Quality Support
 Quality Fee for Service Section
 Limitation Extension
 PO Box 45506
 Olympia, WA 98504-5506
 Telephone (360) 725-1583
 Fax (360) 586-2262

Nursing Facilities

Products that are not reimbursed by MAA when the client resides in a nursing facility

The following drugs are not reimbursed by MAA when dispensed to clients residing in a nursing facility:

Analgesics (OTC)	Jelly, Lubricating
Antacids (OTC)	Laxatives (OTC)
Antidiarrheal medications	Lotions, creams, ointments and oils (OTC)
Antiseptics	Powders
Diabetic test strips and tablets	Prenatal vitamins
Enemas and Enema Supplies (OTC)	Shampoos (medicated)
Insulin needles and syringes	Any other non-legend drugs

The drugs listed above are restricted to home use only.

Medications for nursing facility clients on leave

Nursing facility clients leaving on a weekend pass, attending sheltered workshops, or attending school should have their additional maintenance prescriptions filled for a minimum of 30 days supply.

Nursing facilities should determine which of the following methods will be followed when a nursing facility client goes on leave:

- The client may take the prescription medication home and keep it there for use during the weekend or other nursing facility absences; or
- The client may return the prescription medication to the nursing facility following each leave so that it may be stored for safekeeping. The prescription medication is the client's personal property.

Both of these practices are in accord with state pharmaceutical regulations.

BILLING MAA:

Hardcopy billers must indicate "weekend pass, workshop, or school" in the *Justification/Comments* area on the Pharmacy Statement claim form.

Electronic billers must enter a "Q" as follows:

Tape format..... in the 46th position of the HD record

EMC format in the 54th position of the HD record

Multi-insurer format..... in the 79th position of the P3 record.

Point-of-Sale billers: See Point-of-Sale section.

Emergency Kits

The *emergency kit* is a uniform set of emergency pharmaceuticals furnished to a nursing facility through the pharmacy which provides prescription filling services to that facility. Each kit is specifically set up to meet the needs of the individual nursing facility.

Medications supplied from the emergency kit are to be replaced by an equivalent amount of medications from the client's prescription by the nursing facility. No charge shall be made to MAA for such replacements.

Nursing Facility Unit Dose Delivery Systems

MAA recognizes two types of **Unit Dose Delivery Systems** for nursing facilities:

- **True Unit Dose Delivery System**
- **Modified Unit Dose Delivery System**

Participating True Unit Dose and Modified Unit Dose providers receive the "unit dose dispensing fee" when dispensing in-house unit dose prescriptions. The term *in-house unit dose* applies to bulk pharmaceutical products that are packaged by the pharmacy for true or modified unit dose delivery. Only True Unit Dose providers will receive the unit dose dispensing fee for drugs that are manufacturer packaged in unit dose form (e.g., blister packs, punch cards, etc.). Modified Unit Dose providers will receive the regular pharmacy dispensing fee for drugs that are manufacturer packaged in unit dose form.

Refer to the Reimbursement Section of these billing instructions for MAA Dispensing Fee Allowances for pharmacies.

How do pharmacies become eligible for a unit dose dispensing fee?

To be eligible for a unit dose dispensing fee, a pharmacy must:

1. Notify MAA in writing of its intent to provide unit dose service;
2. Specify the type of unit dose service to be provided;
3. Identify the nursing facility or facilities to be served;
4. Indicate the approximate date unit dose service to the facility or facilities will commence; and
5. Sign an agreement to follow department requirements for unit dose reimbursement.

For information on becoming a True Unit Dose or a Modified Unit Dose provider, please call Provider Enrollment at **1-800-562-6188** or send a written request to:

**DIVISION OF PROGRAM SUPPORT
PROVIDER ENROLLMENT
PO BOX 45562
OLYMPIA WA 98504-5562**

5

How do pharmacies bill MAA under a true or modified unit dose delivery system?

Under a true or modified unit dose delivery system, a pharmacy may bill MAA for the number of drug units dispensed.

The pharmacy must submit an adjustment form or claims reversal of the charge to MAA for the cost of unused drugs returned to the pharmacy on or before the 60th day following the date the drug was dispensed.

Exception:

- Unit dose providers do not have to credit MAA for controlled substances that are returned to the pharmacy.

TO BILL MAA

Hard copy billers must indicate "In-house unit dose" in the *Justification/Comments* area on the Pharmacy Statement claim form.

Electronic billers must enter a "3" as follows:

Tape format in the 46th position of the HD record
 EMC format in the 54th position of the HD record
 Multi-insurer format.....in the 79th position of the P3 record.

Point-of-Sale billers: See Point of Sale section.

Who is responsible for the cost of repackaging client's bulk medications?

Pharmacies may not charge clients or MAA a fee for repackaging a client's bulk medications in unit dose form. The costs of repackaging are the responsibility of the nursing facility when the repackaging is:

- done to conform with a nursing facility's delivery system; or
- for the nursing facility's convenience.

What do pharmacies need to keep in their records?

The pharmacy must maintain detailed records of medications dispensed under unit dose delivery systems. The pharmacy must keep a monthly log for each nursing facility served, including, but not limited to the following information:

- Facility name and address.
- Client's name and patient identification code (PIC).
- Drug name/strength.
- NDC or labeler information.
- Quantity and date dispensed.
- Quantity and date returned.
- Value of returned drugs or amount credited.
- Explanation for no credit given or nonreusable returns; and
- Prescription number.

Upon request, the pharmacy must submit copies of these monthly logs to MAA. MAA may request the pharmacy submit such logs on a monthly, quarterly, or annual basis.

What needs to be submitted annually to MAA?

Along with the completed prescription, pharmacies must annually submit the following to MAA:

- An updated list of nursing facilities served under unit dose systems; and
- The nursing facilities' respective billing period start dates.

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Compounded Prescriptions

Items which are not covered for compounding

- Coloring agents, preservative and/or flavoring agents, unless used as a complete vehicle for compounding (e.g., simple syrup).
- Ingredients manufactured by a company who has not signed a federal rebate agreement.

Chemical supplies

MAA will reimburse compounding ingredients from the following non-contract chemical supply companies:

Labeler Code/Company

00019	M'ckrodt	17317	Amend
00395	Humco Labs	39822	Pharma-Tek
00802	Emerson Labs	49452	A-A Spectrum
10106	J T Baker	53118	Millgood Lab
11299	Torch Labs		

Other chemical supplier's products will not be reimbursed unless the companies allow the state access to their product codes and pricing files (OBRA 90, Section 1927). The company that supplies the compound ingredient has a responsibility to provide an 11-digit billing code or NDC code for each of its products.

How to bill for compounded prescriptions

Pharmacies must bill ingredients used for compounded prescriptions separately using the 11-digit NDC or billing code for each ingredient. Each reimbursable ingredient will receive a separate dispensing fee.

For example, if one compounded prescription requires four different ingredients, a pharmacy will receive four dispensing fees. The additional dispensing fees are payment for the pharmacist's compounding time. A separate fee for compounding time will not be paid.

Pharmacies may also bill one state-assigned preparation fee code for each compounded prescription. The billing codes and maximum allowables are listed in the table below:

NDC	Description	Maximum Allowable
00990-1111-00	Capsules	\$0.10 per capsule
00990-1111-01	Tablets - compressed or triturated	\$0.15 per tablet
00990-1111-02	Suppositories, vaginal, rectal or urethral	\$0.40 per suppository
00990-1111-03	Troches	\$0.40 per troche
00990-1111-04	Pain cocktails	\$2.50 per cocktail dispensing
00990-1111-05	Oral liquids	\$0.04 per ml
00990-1111-06	Topical liquids (small volume 60 ml or less)	\$0.25 per ml
00990-1111-07	Topical liquids (large volume more than 60 ml)	\$0.05 per ml
00990-1111-08	Aseptic technique required	\$5.00 each dispensing
00990-1111-09	Ophthalmic, sterile	\$10.00 each dispensing
00990-1111-10	Injectables, sterile (non-I.V.)	\$10.00 each dispensing
00990-1111-11	Ointments, small volume < 60 GM	\$0.10 per gram
00990-1111-12	Ointments, larger volumes	\$0.05 per gram
00990-1111-13	Enemas	\$0.40 per enema
00990-1111-14	Patches	\$1.70 per patch

Note:

- Preparation fees are not allowed for infusion products.
- Home infusion or other I.V. admixtures will be paid per ingredient plus dispensing fee only.
- Drug reconstitution is not considered compounding.

When is prior authorization required for compounded prescriptions?

Drugs that require prior authorization for payment from MAA require prior authorization whether they are used independently or as an ingredient in a compounded prescription.

Exception: The following items do not require prior authorization for compounding:

Alum Boro	Flexible Collodion	Petrolatum: white, yellow,
Aluminum Chloride	Floxin I.V.	ointment, jelly
Aminophylline	Fungizone	Phenol
Amitriptyline/Chlordiazepoxide	Glycerin (non-suppository)	Podophyllum Resin
Ammoniated Mercury 5%	Greaseless Ointment Base	Polybase
Aqua Care HP	Green Soap	Polytar
Aromatic Elixir	Heparin Sodium, Solution	Potassium Iodide
Aureomycin, plain (IV, IM)	Hydrocream Base	Salicylic Acid
Balnetar	Hydrophilic Base	Silver Nitrate 1%
Benoquin, plain	Isoproterenol HCL	Simple Syrup
Boric Acid 5%	Kerodex 51	Sodium Chloride in 5% Dextrose
Calamine Phenolated	Kerodex 71	Solaquin Forte, plain
Camphor	Lac-Hydrin	Sulfur 10%, plain
Cefobid	Lactated Ringers	Tannic Acid
Cefotan	Lactose	Tazicef in Dextrose
Cetaphil	Lanolin Toilet, plain	Theophylline in 5% Dextrose
Cherry Syrup	Lanolin Anhydrous, plain	Thymol
Colloid	Lanolin Hydrous, plain	Tobramycin Sulfate
Cort-Dome	Lidocaine HCL in 5%Dextrose	Travasol
Desowen	Menthol	Unibase
Domeboro	Methylcellulose	Urea
Dopamine HCL in 5% Dextrose	Moisturel	Xylocaine
Eucalyptus Oil	Monistat-Derm	Zetar
Eucerin Plus	Nitroglycerin in D5W, plain	Zinc Oxide
Fattibase	Nivea Skin Oil	
	Oxacillin Sodium	

BILLING MAA

Hard copy billers must indicate "Compound Prescription" in the *Justification/Comments* area on the Pharmacy State claim form.

Electronic billers must enter a "2" as follows:

Tape format..... in the 46th position of the HD record

EMC format..... in the 54th position of the HD record

Multi-insurer format in the 79th position of the P3 record.

Point-of-Sale billers: See Point-of-Sale section.

Prior Authorization

When should a pharmacist obtain prior authorization?

Pharmacists are required to obtain prior authorization for many drug products and items before providing them to the client. MAA reviews authorization requests for medical necessity. The requested service or item must be covered within the scope of the client's program.

Exception:

- In emergent situations, pharmacists may fill prescription drugs that require authorization without an authorization number. Justification for the emergency fill must be provided to MAA no later than 72 hours after the fill date (excluding weekends and Washington State holidays).

What information should a pharmacist have ready before calling MAA for an authorization number?

When calling for an authorization number, pharmacists must have the following information ready:

1. Client's Patient Identification Code (PIC)
2. Medical Assistance provider number (beginning with "6")
3. Appropriate National Drug Code (NDC)
4. Justification for the requested service. Describe the medical need for the service or item and condition of the patient or the diagnosis.
5. Date(s) of service.

MAA may request additional information, depending on the drug product.

When calling to obtain continued prior authorization, please refer to the **original authorization number**.

Note: **Prior authorization does not necessarily guarantee payment.**
All administrative requirements (client eligibility, claim timeliness, etc.) must be met before reimbursement will be made.

Where to call for prior authorization

For drug products requiring authorization,
please call:

Drug Utilization & Review
1-800-848-2842

8

Mail or fax your information to:

Division of Health Services Quality Support
Drug Utilization & Review
PO Box 45506
Olympia, WA 98504-5506
Fax: (360) 586-5299

9

What to do if a pharmacist receives a denial code

The following table indicates the type of Denial Edit/Conflict Code providers will receive if they submit a POS claim for a drug that requires prior authorization number. Please have your MMIS 7-digit provider number (beginning with a “6”) available when you contact MAA to request prior authorization.

DENIAL EDIT/ CONFLICT CODE	REASON CLAIM DENIED	ACTION
30 PA Required	Expedited drugs requiring prior authorization.	Pharmacy should submit using appropriate expedited PA procedure.
75 PA Required	<p>Brand Name Medications listed below require prior authorizations:</p> <p>Percodan Tuinal Percocet Seconal Valium Nembutal Vicodin Demerol w/APAP Xanax Anexsia</p> <p>Non-HCFA Rebate Company Products: Duofilm Rimso-50</p> <p>Other Drugs: All non-formulary products.</p>	Pharmacy or physician should call MAA for authorization.

Medicare Part B/Medicaid Crossover HCFA-1500 Claim Form

Federal law requires a claim “paid” by Medicare to be submitted to Medicaid within six (6) months of the Medicare statement date.

When the words, “This information is being sent to either a private insurer or Medicaid fiscal agent,” appear on your Medicare Remittance Notice, it means that your claim has been forwarded to MAA or a private insurer for deductible and/or coinsurance processing.

The HCFA-1500 claim form, used for Medicare/Medicaid Benefits Coordination, cannot be used in the Point of Sale (POS) system.

If you have received a payment from Medicare, but it does not appear on your MAA Remittance and Status Report (RA) within 45 days from Medicare’s statement date, you should bill MAA directly.

The Medicare/Medicaid billing form (HCFA-1500) must be submitted to MAA, Claims Processing Office:

**Division of Program Support
PO Box 9247
Olympia WA 98507-9247**

General Instructions

- Use an original, red and white HCFA-1500 (U2) (12-90) claim form.
- Enter only one (1) procedure code per detail line (fields 24A-24K). If you need to bill more than six (6) lines per claim, please complete an additional HCFA-1500 claim form.
- All information must be centered within the space allowed.
- Use upper case (capital letters) for all alpha characters.
- Do not write, print, or staple any attachments in the bar area at the top of the HCFA-1500 claim form.
- Attach complete, legible Medicare EOMB or claim will be denied.

FIELD DESCRIPTION

1a. Insured's I.D. No.: Required. Enter the Patient Identification Code (PIC) - an alphanumeric code assigned to each Medical Assistance client - exactly as shown on the Medical Assistance IDentification (MAID) card. This information consists of the client's:

- a) First and middle initials (a dash [-] *must* be used if the middle initial is not available).
- b) Six-digit birthdate, consisting of *numerals only* (MMDDYY).
- c) First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tiebreaker.
- d) An alpha or numeric character (tiebreaker).

For example:

- 1. Mary C. Johnson's PIC looks like this: MC010633JOHNSB.
- 2. John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100226LEE B.

NOTE: The MAID card is your proof of eligibility.

2. Patient's Name: Required. Enter the last name, first name, and middle initial of the MAA client (the receiver of the services for which you are billing).

3. Patient's Birthdate: Required. Enter the birthdate of the MAA client. **Sex:** Check **M** (male) or **F** (female).

4. Insured's Name (Last Name, First Name, Middle Initial): When applicable. If the client has health insurance through employment or another source (e.g., private insurance, Federal Health Insurance Benefits, CHAMPUS, or CHAMPVA), list the name of the insured here. Enter the name of the insured except when the insured and the client are the same - then the word *Same* may be entered.

5. Patient's Address: Required. Enter the address of the Medicaid client who has received the services you are billing for (the person whose name is in *field 2*).

9. Other Insured's Name: Secondary insurance. When applicable, enter the last name, first name, and middle initial of the insured. If the client has insurance secondary to the insurance listed in *field 11*, enter it here.

9a. Enter the other insured's policy or group number *and* his/her Social Security Number.

9b. Enter the other insured's date of birth.

9c. Enter the other insured's employer's name or school name.

9d. Enter the insurance plan name or the program name (e.g., the insured's health maintenance organization, or private supplementary insurance).

Please note: DSHS, Welfare, Provider Services, Healthy Kids, First Steps, Medicare, Indian Health, PCCM, Healthy Options, PCOP, etc., are inappropriate entries for this field.

- 10. Is Patient's Condition Related To:** Required. Check *yes* or *no* to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in *field 24*. ***Indicate the name of the coverage source in field 10d*** (L&I, name of insurance company, etc.).
- 11. Insured's Policy Group or FECA (Federal Employees Compensation Act) Number:** Primary insurance. When applicable. This information applies to the insured person listed in *field 4*. Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate that the client has other insurance coverage and MAA pays as payor of last resort.
- 11a. Insured's Date of Birth:** Primary insurance. When applicable, enter the insured's birthdate, if different from *field 3*.
- 11b. Employer's Name or School Name:** Primary insurance. When applicable, enter the insured's employer's name or school name.

- 11c. Insurance Plan Name or Program Name:** Primary insurance. When applicable, show the insurance plan or program name to identify the primary insurance involved. (*Note: This may or may not be associated with a group plan.*)
- 11d. Is There Another Health Benefit Plan?:** Required if the client has secondary insurance. Indicate *yes* or *no*. If *yes*, you should have completed *fields 9a.-d*. If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check *yes*. **If 11d is left blank, the claim may be processed and denied in error.**
- 19. Reserved For Local Use -** Required. When Medicare allows services, enter *XO* to indicate this is a crossover claim.
- 22. Medicaid Resubmission:** When applicable. If this billing is being resubmitted more than six (6) months from Medicare's paid date, enter the Internal Control Number (ICN) that verifies that your claim was originally submitted within the time limit. (The ICN number is the *claim number* listed on the Remittance and Status Report.) Also enter the three-digit denial Explanation of Benefits (EOB).
- 24. Enter only one (1) procedure code per detail line (fields 24A - 24K).** **If you need to bill more than six (6) lines per claim, please use an additional HCFA-1500 claim form.**

24a. Date(s) of Service: Required. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., August 4, 2000 = 080400). **Do not use slashes, dashes, or hypens to separate month, day or year (MMDDYY)**

24b. Place of Service: Required. Enter a **9**.

24c. Type of Service: Required. Enter a **9**.

24d. Procedures, Services or Supplies CPT/HCPCS: Required. Enter appropriate HCPCS.

Coinsurance and Deductible:
Required. Enter the total combined and deductible for each service in the space to the right of the modifier on each detail line.

24e. Diagnosis Code: Required. Enter appropriate diagnosis code for condition or use **V98.0**.

24f. \$ Charges: Required. Enter the amount you billed Medicare for the service performed. If more than one unit is being billed, the charge shown must be for the total of the units billed. Do not include dollar signs or decimals in this field. Do not add sales tax.

24g. Days Or Units: Required. Enter the appropriate units.

24k. Reserved for Local Use: Required. Use this field to show Medicare's allowed charges. Enter the Medicare's allowed charge on each detail line of the claim (see sample).

26. Your Patient's Account No.: Not required. Enter an alphanumeric ID number, for example, a medical record number or patient account number. This number will be printed on your Remittance and Status Report under the heading *Patient Account Number*.

27. Accept Assignment: Required. Check **yes**.

28. Total Charge: Required. Enter the sum of your charges. Do not use dollar signs or decimals in this field.

29. Amount Paid: Required. Enter the Medicare Deductible here. Enter the amount as shown on Medicare's Remittance Notice and Explanation of Benefits. If you have more than six (6) detail lines to submit, please use multiple HCFA-1500 claim forms (see field 24) and calculate the deductible based on the lines on each form. **Do not include coinsurance here.**

30. Balance Due: Required. Enter the Medicare Total Payment. Enter the amount as shown on Medicare's Remittance Notice or Explanation of Benefits. If you have more than six (6) detail lines to submit, please use multiple HCFA claim forms (see field 24) and calculate the Medicare payment based on the lines on each form. **Do not include coinsurance here.**

32. **Name and Address of Facility Where Services Are Rendered:**
Required. Enter Medicare Statement Date *and* any Third-Party Liability Dollar Amount (e.g., auto, employee-sponsored, supplemental insurance) here, if any. If there is insurance payment on the claim, you must also attach the insurance Explanation of Benefits (EOB). **Do not include coinsurance here.**

33. **Physician's, Supplier's Billing Name, Address, Zip Code and Phone #:** Required. Enter the pharmacy's *Name, Address,* and *Phone #* on all claim forms. Enter your seven-digit pharmacy provider number (which begins with six [6] here). **Do not use your NABP number for Medicare/Medicaid crossover claims.**

Sample HCFA-1500 Claim Form

Reimbursement

General Information

MAA bases its prescription drug reimbursement on (1) the standard 11-digit National Drug Code (NDC) (5-4-2 format), and (2) the quantity filled.

MAA's total reimbursement for a prescription drug must not exceed the lowest of:

- (a) Estimated acquisition cost (EAC) plus a dispensing fee;
- (b) Maximum allowable cost (MAC) plus a dispensing fee;
- (c) Federal Upper Limit (FUL) plus a dispensing fee;
- (d) Actual acquisition cost (AAC) plus a dispensing fee for drugs purchased under section 340 B of the Public Health Services (PHS) Act and dispensed to medical assistance clients; or
- (e) The provider's usual and customary charge to the non-Medicaid population.

[WAC 388-530-1300]

Bill your usual and customary charge (the charge you bill the general public) when billing MAA.

Note: This means that if the usual and customary prescription charge to the general public is either: 1) discounted; 2) reduced (due to coupon offered); or 3) offered free, then the prescriptions billed to Medicaid must reflect the same discount or free charge.

Pharmacy promotional incentives, not related to reducing the usual and customary fee, must be offered to DSHS clients without discrimination. (Example: A \$5.00 off coupon for purchases elsewhere in the store.)

Payment

MAA may be billed only **after** you provide a service to an eligible client. Delivery of a service or product does not guarantee payment. For example, MAA does not make payment when:

- The request for payment is not presented within the 365 day billing limit.
- The service or product is not medically necessary or is not covered by MAA;
- The client has third party coverage and the third party pays as much as, or more than, MAA allows for the service or product; **or**
- The service or product is covered in the managed care capitation rate.

Tax

Tax is computed on items determined to be taxable according to the Washington State Department of Revenue.

Estimated Acquisition Cost (EAC)

First DataBank derives the Average Wholesale Price (AWP) of each product based on information they receive directly from each manufacturer or labeler. MAA determines the appropriate percentage of the AWP that represents the Estimated Acquisition Cost (EAC). Most drugs are reimbursed at the EAC plus a dispensing fee.

Currently applied EAC percentages are:

Schedule II drugs	100% of AWP
All others	89% of AWP

Dispensing Fees

MAA uses a three-tier dispensing fee structure with an adjusted fee allowed for pharmacies that participate in the Modified Unit Dose and/or True Unit Dose programs. *See Section E. for Unit Dose billing instructions.*

Listed below are the MAA dispensing fee allowances (**effective 7/1/00**) for pharmacies:

High-volume pharmacies (over 35,000 Rxs/yr)	\$4.14/Rx
Mid-volume pharmacies (15,000-35,000 Rxs/yr)	\$4.44/Rx
Low volume pharmacies (under 15,000 Rxs/yr)	\$5.12/Rx
Unit Dose Systems	\$5.12/Rx

A provider's dispensing fee is determined by the volume of prescriptions the pharmacy fills for MAA clients **and** the general public as indicated on the annual prescription count survey distributed to the pharmacies by MAA.

REMEMBER to include MAA clients **and** the general public in your total prescription count.

NOTE: Sale or transfer of business ownership will invalidate your Core Provider Agreement. The new owner must call the Provider Enrollment Unit (see Important Contacts) to acquire a Core Provider Agreement.

Return the annual prescription count survey to:

Provider Enrollment Unit
Division of Program Support
PO Box 45562
Olympia, WA 98504-5562

Drug Quantities

Quantities must be billed using the metric quantity or metric decimal as appropriate. See Section K – Point-of-Sale, NCPDP payor sheet (pages K.7 and K.9).

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Point-of-Sale (POS)

What is Point-of-Sale (POS)?

The POS system finalizes claims at the point-of-entry as either "paid" or "denied." Due to the on-line nature of claims submission, a prescription may be identified more than once on your weekly Remittance and Status Report (RA). Please be sure to track each transaction completely before inquiring with MAA. A prescription which is denied and subsequently paid on the same RA will have EOB 402 attached to the denied claim(s). The POS system uses the National Council for Prescription Drug Programs (NCPDP) version 3.2C format.

Any claim that requires a hard copy attachment must be submitted as a paper claim. We have attempted to eliminate the need for attachments unless it is absolutely necessary.

Do pharmacies have to use the on-line POS system?

No! Pharmacies that choose not to use the on-line POS system can still submit their claims through hard copy billing (paper claims) or electronically using MAA's approved record formats. These claims will be processed by MAA through the POS system. **ALL CLAIMS ARE PROCESSED AND EDITED THROUGH THE POS SYSTEM** regardless of how they are submitted.

Do pharmacies need a separate agreement with MAA to use POS?

No! A separate agreement with MAA is not required to use POS. Simply contact your software vendor or switch vendor.

How long do I have to bill?

State law requires that you present your final bill to MAA for reimbursement no later than 365 days from the date of service. (RCW 74.09.160)

How do I bill for a baby who is using his/her parent's PIC?

Hardcopy billers must indicate "Baby using parent's PIC" in the *Justification/Comments* area on the Pharmacy Statement claim form.

Electronic billers must enter a "B" as follows:

Tape format..... in the 46th position of the HD record
 EMC format in the 54th position of the HD record
 Multi-insurer format in the 79th position of the P3 record.

Point-of-Sale billers must enter a "2" in the Eligibility Clarification Code field.

National Drug Code (NDC)

The NDC is the 11-digit code assigned to all prescription drug products by the labeler or distributor of the product under FDA regulations.

The provider must always use the actual, complete 11-digit NDC from the dispensing container.

MAA accepts only the 5-4-2 NDC format. *All 11 digits, including zeros, must be entered.* The three segments of the NDC are:

SAMPLE NDC: 12345-6789-10
12345 = labeler code
6789 = product code
10 = package size

Overriding a PRO-DUR denied claim

When a Pro-DUR denied claim needs to be overridden, pharmacy providers may enter one MAA-approved DUR Conflict Code (see below for list) from each category in the following order, as long as the indicated situations exist and the pharmacy retains documentation in its files:

1. Two byte alpha DUR Conflict Code, *followed by...*
2. Two byte alphanumeric DUR Intervention Code, *followed by...*
3. Two byte alphanumeric DUR Outcome Code

Electronic submitters may enter the DUR codes in the following fields:

TAPE FORMAT: in the 133-138 position of the DD record

EMC FORMAT: in the 149-154 position of the DD record

MULTI-INSURER FORMAT: in the 75-80 position of the P2 record.

An example of a valid entry would be **HDM01G**.

Paper claims must note the appropriate DUR Conflict Code in the *Justification/Comments* field, if applicable.

By placing codes into the claim, the provider is certifying that the indicated DUR code is true and documentation is on file. If you have questions regarding DUR codes, contact the Provider Relations Unit at 1-800-562-6188.

MAA Approved NCPDP DUR Codes

DUR CONFLICT CODES

AT	Addictive toxicity
CH	Call Help Desk
DA	Drug allergy alert
DC	Inferred drug disease precaution
DD	Drug-drug interactions
DI	Drug incompatibility
DL	Drug lab conflict
DF	Drug good interaction
DS	Tobacco use precaution
ER	Overuse precaution
HD	High dose alert
IC	Iatrogenic condition alert
ID	Ingredient duplication
LD	Low dose alert
LR	Underuse precaution
MC	Drug disease precaution
MN	Insufficient duration alert
MX	Excessive duration alert
OH	Alcohol precaution
PA	Drug age precaution

PG	Drug pregnancy alert
PR	Prior adverse drug reaction
SE	Side effect alert
SX	Drug gender alert
TD	Therapeutic duplication

DUR INTERVENTION CODES

M0 (M, ZERO)	MD interface
P0 (P, ZERO)	Patient interaction
R0 (R, ZERO)	Pharmacist reviewed

DUR OUTCOME CODES

1A	Filled, false positive
1B	Filled as is or filled for Medicare-Medicaid eligible client following Medicare denial
1C	Filled with different dose
1D	Filled with different directions
1F	Filled with different quantity
1G	Filled after prescriber approval obtained

Prospective Drug Use Review Edits

MAA is providing a system-facilitated Prospective Drug Use Review screening service as a part of the POS system. High dose and therapeutic duplication edits post and claims are denied when potential drug therapy problems are identified. Once pharmacists have conducted their professional review, the following MAA-approved NCPDP DUR intervention and outcome codes can be used to override the claims denial.

DENIAL EDIT/ CONFLICT CODE	REASON FOR CLAIMS DENIAL	ACTION
88 HD ProDUR Edit High Dose Alert	Any drug to be dispensed for daily dose in excess of the Maximum Daily Dose by 100%.	Pharmacist should verify that the quantity and/or day's supply was entered correctly. If yes, pharmacist may need to contact prescriber regarding appropriate prescribed quantity. MAA approved NCPDP DUR codes can be used to certify the indicated situation exists.
Drug Age & Drug Gender Edits	MAA will not cover prescriptions that are not medically necessary.	Pharmacist should verify appropriateness of prescription. Contact Provider Inquiry if a systems error is suspected.
88 TD ProDUR Edit Therapeutic Duplication Alert	Concurrent prescriptions for drugs in the same therapeutic class.	Pharmacist should use personal judgement or confer with physician or patient to determine appropriateness of duplicate therapy. If appropriate, pharmacist may use MAA approved applicable NCPDP DUR, intervention and outcome code to override claim denial (approved NCPDP codes are listed on the previous page), or pharmacy may call Consultec Help Desk for assistance with codes.

Other Prospective Drug Use Review Edits

DENIAL EDIT	REASON FOR CLAIMS DENIAL	ACTION
79 or 83	Same drug, different strength	Pharmacist should check prescriber ID field and enter prescriber ID on each claim (for both strengths). If different prescribers, pharmacist calls for authorization 1-800-848-2842.
83	Duplicate claim	None

NCPDP Payor Sheet for Washington Medicaid Version 3.2C

Data Element	Format	Required Status	Description/Valid Values
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Required Transaction Header Section			
ANSI BIN	NCPDP	Required	Enter "610084"
Version Number	NCPDP	Required	Enter "3C"
Transaction Code	NCPDP	Required	Valid values: 00, 01, 02, 03, 04, 11, 24, 31, 32, 33, 34
Processor Control Number	10 A/N	Required	Definition: CICSWARX - Production Claims CICSACPT - Test Claims
Pharmacy ID	NCPDP	Required	Enter your seven-digit NABP Provider #.
Group Number	7 A/N	Required	Client ID is position 1-3 Group Number is position 4-7. For Washington Medicaid, use 2507850 for all claims.
Cardholder ID Number	14 A/N	Required	Use the recipient's 14-digit Medicaid ID #
Person Code	NCPDP	Optional	Always "01" if an entry required by your system.
Date of Birth	NCPDP	Required	8 digit format: CCYYMMDD
Sex Code	NCPDP	Required	
Relationship Code	NCPDP	Required	
Other Coverage Code*	NCPDP	Conditional	0 – Not Specified 1 – No Other Coverage Identified 2 – Capitated Service Co-pay Only When filing for a situation where no fee for service is applicable to this claim, use code "2" & leave the Other Payor Amount field blank. 3 – Other Coverage Exists - This Claim Not Covered or Paid at \$0. 4 – Other Coverage Exists - Payment Not Collected Due to Exclusive Network.
Date Filled	NCPDP	Required	

NCPDP Payor Sheet for Washington Medicaid Version 3.2C

Data Element	Format	Required Status	Description/Valid Values
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Optional Header Information Section

Customer Location	NCPDP	Conditional	Enter "02" to indicate an ITA Claim. Enter "03" for Nursing Home residents. Enter "11" for Hospice patient prescriptions unrelated to the terminal condition.
Eligibility Clarification Code	NCPDP	Conditional	Enter code "2" to indicate a claim where that baby is using the parent's ID.
Patient First Name	NCPDP	Optional	
Patient Last Name	NCPDP	Optional	

Required Claim Header Information Section

Rx Number	NCPDP	Required	
New/Refill Number	NCPDP	Required	
Metric Quantity	NCPDP	Conditional	Enter whole unit quantities only. (Note: Do not enter metric decimal quantities here, see Metric Decimal Qty.)
Days Supply	NCPDP	Required	
Compound Code	NCPDP	Conditional	Bill each component of a compounded prescription as a separate claim with its own NDC and quantity. Enter Compound Code "2" for each component claim.
NDC Number	NCPDP	Required	
Dispense As Written (DAW) Code/Product Selection Code	NCPDP	Optional	This field is not used at this time.
Ingredient Cost	NCPDP	Required	
Prescriber ID	7 A/N	Required	If known, enter the Medicaid Provider # of the prescriber. If not known, enter as many characters of the last name as possible.
Date Rx Written	NCPDP	Required	
Usual & Customary Charge	NCPDP	Required	

NCPDP Payor Sheet for Washington Medicaid Version 3.2C

Data Element	Format	Required Status	Description/Valid Values
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Optional Claim Information Section			
Prior Authorization/ Medical Certification Code & Number	NCPDP	Conditional	If applicable, enter the Prior Authorization number given to you by the PA Unit. Enter Medical Certification Code "2" to indicate an MHCP Prescription. Enter "5" to indicate a Lost or Stolen Medication. Enter "8" to indicate a Take Home Supply of Medications for School or Camp or Suicide Risk/potential abuse.
Level of Service	NCPDP	Optional	This field is not used.
Diagnosis Code	NCPDP	Optional	Enter the ICD-9 diagnosis code, if known.
Unit Dose Indicator	NCPDP	Conditional	Enter "3" for in-house unit dosed prescriptions.
Gross Amount Due*	NCPDP	Required	Enter the same amount that was entered for ingredient cost before subtracting any other insurance payments.
Other Payor Amount	NCPDP	Conditional	Enter the total amount of the payment(s) received from other payor(s).
Patient Paid Amount	NCPDP	Optional	
Incentive Amount Submitted	NCPDP	Optional	
DUR Conflict Code	NCPDP	Conditional	Enter when resubmitting a claim previously denied for edit 88 (DUR problem). Enter the applicable DUR Conflict Code to which you are responding.
DUR Intervention Code	NCPDP	Conditional	Enter when resubmitting a claim previously denied for edit 88 (DUR problem). Enter the applicable DUR Intervention Code.

NCPDP Payor Sheet for Washington Medicaid Version 3.2C

Data Element	Format	Required Status	Description/Valid Values
DUR Outcome Code	NCPDP	Conditional	Enter when resubmitting a claim previously denied for edit 88 (DUR alert), edit 79 (refill too soon) due to a dosage change, or edit 70 (client covered by Medicare). Enter the applicable DUR Outcome Code for the corresponding edit 88. Use outcome code 1C for edit 79 for dosage changes only . Use outcome code 1B for edit 70 following Medicare denial for a Medicaid-covered drug.
Metric Decimal Qty	NCPDP	Conditional	Enter metric decimal quantities only. (Note: Do not enter whole unit quantities here - see Metric Quantity.)
Primary Payor Denial Date	NCPDP	Conditional	If applicable, enter the date in CCYYMMDD format that the other carrier denied this claim.

Other Information

- An optional data element means that the user should be prompted for the field but does not have to enter a value. A conditional data element means that certain situations may warrant an entry in order to avoid a claim rejection.
- Duplicate claims will be rejected with an “83” error (indicating claim has been previously paid).
- DUR information, if applicable, will appear in the message text of the response.

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Completing Pharmacy Statement Form 525-106

The boxes on the Pharmacy Statement form 525-106 will be referred to as *fields*. Only those fields that are required for billing will be addressed.

Pharmacy Name And Address And

Provider Number - Enter your name and address as recorded with the Division of Program Support. Enter your NABP (National Association of Boards of Pharmacy) number. Please use this number on all forms.

Patient Identification (PIC) - An alpha-numeric code assigned to each Medical Assistance client which consists of:

- a) First and middle initials (or a dash (-) if the middle initial is not indicated)
- b) Six-digit birthdate, consisting of MMDDYY.
- c) First five letters of the last name (or blanks if less than five characters)
- d) Alpha or numeric character (tie breaker)

Patient Name And Address - Enter the client's last name, first name and middle initial. Enter the client's address.

Prescription Number - Assign in sequence with regular prescriptions filled by the pharmacy. The original prescription number may be used for refills, or a new number may be assigned. (MAA accepts a maximum of seven numeric characters for this purpose.)

Refill Code - Indicate which refill of the prescription this claim is for (enter "1" if this is the first refill of the prescription; enter "2" if this is the second refill of the prescription, etc.)

Nursing Care Facility - Check *Yes* if the prescription was provided to a client residing in a licensed nursing facility; otherwise, check *No*. Note: congregate care facilities are not considered nursing facilities. If a client resides in a congregate care facility, check *No*.

Est. Days Supp. - Enter the estimated days' supply.

Authorization Number - Enter the nine-digit authorization number assigned by MAA when required.

Fill Date - Enter the date the prescription was filled.

National Drug Code (NDC) - Enter the manufacturer's complete 11-digit NDC from the dispensing container.

All digits, including zeros, must be entered.

The three sections in the NDC field **must** have numbers entered in the correct section.

The *labeler code* portion of the 11-digit NDC will always consist of five numeric characters; the *product code* portion consists of four numeric characters; and the *package size* will be two numeric characters.

SAMPLE NDC NUMBER: 12345-6789-10

12345 = labeler code

6789 = product code

10 = package size

Drug Name - Enter a description of the drug prescribed, showing strength when applicable.

Quantity Filled - Enter quantity filled.

Prescriber's I.D. - Enter the seven-digit MAA provider identification number of the prescriber. Be sure to use the unique individual provider identification number. Do not complete with a group billing number. For prescribers not enrolled in the Medical Assistance program, enter the prescriber's name. If this field is left blank, the claim will be denied. Pharmacists who have received approval from the Washington State Board of Pharmacy for Pharmacist Prescriptive Authority *will use the MAA provider number of the physician who has granted protocol authorization.*

Prescription (Direction For Use) - Enter the *Sig.*

Date Written - Enter the date on which the physician wrote/ordered the prescription.

Generic - Enter an "X" under *Yes* or *No* to indicate if a generic substitution is permitted by the physician.

Justification/Comments - Enter any other information applicable to this prescription.

Total Charge - Enter your usual and customary charge, including your dispensing fee. Do not include tax.

Insurance Paid Amount - Enter any amount paid by insurance; do not enter co-pay amount here. (Refer to TPL section.)

Balance Due - Enter the amount due after deducting patient pay or insurance.

Sample Pharmacy Statement Form 525-106

Maximum Allowable Cost Program

Automated Maximum Allowable Cost (AMAC) Program

AMAC is part of the MAA's Cost Savings Initiative as required in Section 209 (14) of the 1995-1997 Appropriations Act. It represents an alternative to selective contracting as developed and agreed to in cooperation with pharmacy representatives.

AMAC is applied to all multi-source drugs not currently on the Maximum Allowable Cost (MAC) list. There must be at least three drugs in a Generic Code Number (GCN) sequence, and at least one of the manufacturer/labelers must participate in the federal rebate contract program. Drug products are paid at the Estimated Acquisition Cost (EAC) of the third lowest priced product in that sequence, or at the EAC of the lowest priced contract drug in that sequence, whichever is more. If the price established in this way exceeds the federal upper limit, the price will be set at the federal upper limit. If the specific product dispensed is priced lower than the established price, the product will be paid at EAC of the product furnished.

AMAC does not affect drugs currently on the MAC program.

Bill MAA your usual and customary charge. Reimbursement will be the lower of the billed charge or the maximum allowable fee.

Maximum Allowable Cost Program (MAC)

Maximum allowable cost reimbursement for prescription drug products applies to a listing of specific, therapeutically equivalent multiple-source drugs with ample availability.

For these specific drug forms and strengths, MAA will reimburse a maximum allowable cost (MAC). MAC prices apply to any quantity filled and will be prorated as necessary. Brand name and generic drugs with a MAC established are reimbursed at the MAC price, unless prior authorization from MAA is obtained for the brand name drug. If prior authorized, reimbursement is made at the appropriate percent of AWP (i.e., the Estimated Acquisition Cost [EAC]).

The MAC fee schedule is provided for pricing information only. The price shown is the maximum allowable cost per unit. The unit cost relates to the form in which the drug is distributed (e.g., per tablet or capsule, milliliter, gram, packet, or vial).

The reimbursement rate listed for each drug entity includes brand as well as generic products. Pharmacists who dispense the brand product without prior authorization (based on clinically documented medical necessity) will received the MAC reimbursement.

Bill MAA your usual and customary charge. Reimbursement will be the billed charge or the maximum allowable fee, whichever is less.

IMPORTANT: Drugs listed in the MAC fee schedule are subject to prior authorization or other coverage rules contained in these billing instructions.

Over-the-Counter Medications

The following is a list of the over-the-counter (OTC) medications covered by the Medical Assistance Administration Prescription Drug Program.

Drugs	Restrictions
Acetaminophen 300-325 mg, 500-650mg	Dispense in 200s
Acetaminophen elixir	
Antacid suspensions	Home use only, not in nursing home
Antacid tablets	Home use only in 100s, not in nursing home
Aspirin	Dispense in 200s
Aspirin children's	
Axid AR	
Bacitracin ointment	
Bisacodyl supp and tab	Home use, kidney patients only
Brompheniramine liquid	
Brompheniramine/phenylpropanolamine elixir	
Bronkometer	
Calcium carbonate 500-750mg	Dispense in 100s
Calcium gluconate/lactate	Dispense in 100s
Chlorpheniramine	
Clotrimazole vaginal cream	
Condoms (all types)	
Contraceptive gel, foam, cream, suppositories, sponges	
Delsym suspension	
Diphenhydramine caps and elixir	
Docusate caps	Home use only, not in nursing homes
Ferrous fumarate/gluconate/sulfate	Dispense in 100s
Guaifenesin DM or codeine elixir	
Hypotonic tears	
Imodium AD	
Insulin (all types)	
Ipecac syrup	
Lacri-lube	
Miconazole vaginal cream	
Mylanta AR	
Nasalcrom spray	
Niacin	100s not sustained release (SR)
Nicotinic acid	100s not sustained release (SR)
Nix rinse	
Nu-iron	Kidney patients only
Oxymetazoline nasal spray	

Over-the-Counter List Continued

Drugs	Restrictions
Parepectolin	
Pepcid AC	
Pedialyte soln	
Pseudoephedrine and w/chlorpheniramine	
Pyridoxine 50 mg	
Quinine 300-325mg	
Shur-clens	
Tagamet HB 100 mg	
Tearisol	
Triple antibiotic oint	
Tripolidine w/pseudoephedrine	
Vitamin C	Nursing home use only for urine acidification
Zantac 75	

Please note: Items contained on this list are subject to the Maximum Allowable Cost (MAC) and the Automatic Maximum Allowable Cost (AMAC) schedules.

Less-Than-Effective Drug Index

The following list contains drugs classified by the Food and Drug Administration (FDA) as Less-Than-Effective (DESI) drugs. *The pharmacist assumes full responsibility for prescriptions filled erroneously with less-than-effective drugs. MAA will not pay for such prescriptions under any circumstances.*

FDA classifications of specific drug indications abstracted from the *Federal Register* and listed are based on findings by the National Academy of Sciences/National Research Council (NAS/NRC) Drug Efficacy Study.

When a drug is reviewed by the FDA, a Notice of Opportunity for a Hearing (NOOH) and the date of that notice are published in the *Federal Register*. Once the FDA's final determination of ineffectiveness is made, MAA will immediately stop payment for a Less-Than-Effective drug back to the NOOH date originally published in the *Federal Register*.

MAA will not pay for a drug's trade name or dosage form if, by its generic makeup and route of administration, it is identical, similar, or related to a drug on this list.

Drug Rebate Program

The Omnibus Budget Reconciliation Act (OBRA) of 1990 mandates that states claim Federal Financial Participation (FFP) *only* for outpatient prescription drugs supplied by a drug manufacturer who has entered into a *drug rebate contract* with the Health Care Financing Administration (HCFA). As a result, MAA will cover only outpatient prescription drugs supplied by contract manufacturers (unless otherwise noted below).

Please Note: It is very important for pharmacy providers to bill the actual NDC for the drug dispensed and to accurately report the quantity filled when submitting claims for reimbursement. Use of an incorrect NDC or inaccurate reporting of a drug quantity will cause MAA to report false drug rebate calculations to manufacturers.

CONTRACT DRUGS:

Payable contract drugs are outpatient drugs supplied by a manufacturer who has entered into a drug rebate agreement with HCFA.

NONCONTRACT PAYABLE DRUGS:

These drugs are supplied by drug manufacturers who have not entered into a drug rebate agreement with HCFA. The following *noncontract drugs* (all strengths) are payable *only if prior authorized*, unless otherwise noted.

DANAZOL
DUOFILM
RIMSO-50
TAPAZOLE
THEREVAC PLUS (see the expedited authorization section)
THEREVAC SB (see the expedited authorization section)
YODOXIN

Following are alphabetic and numeric (by labeler code) lists of drug manufacturers participating in the HCFA drug rebate program.

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Drug Formulary

General Information

The Drug Formulary is a list of drugs which **do not** require prior authorization. It is provided in alphabetical order and by therapeutic classification.

IMPORTANT: Products listed in the drug formulary are **subject to all other coverage rules**. Be sure to check:

- The participating drug rebate manufacturer/labeler list.
- The list of drugs included in the nursing home per diem.
- DESI Drugs.
- Obsolete/Terminated Drugs.

If the product **is not** listed in the drug formulary, be sure to check the following **before** calling for prior authorization.

- The participating drug rebate manufacturer list. If the manufacturer/labeler is not on the list, the drug is **not** reimbursable by MAA. (*See list of exceptions in the Drug Rebate section of these billing instructions.*)
- The list of drugs included in the nursing home per diem.
- The Expedited Authorization section of these billing instructions.

REMEMBER: Drugs listed in the formulary **may** or **may not** be included in the MAC program.

For drugs requiring authorization, refer to the Prior Authorization section of these billing instructions.

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